CHAPTER II: CLAIMS PROCESSING SYSTEMS MODIFICATION

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OBJECTIVE

This chapter provides participants with an overview of the claims processing system and billing changes under the outpatient prospective payment system

SERVICES INCLUDED WITHIN THE SCOPE OF THE HOSPITAL OUTPATIENT PPS

The following services are included in the scope of hospital outpatient PPS:

Included Services

- Certain services for patients who have exhausted their Part A benefits
- Partial hospitalization services for CMCHs
- Services designated by the Secretary: surgical procedures, radiology (including radiation therapy), clinic visits, partial hospitalization for the mentally ill, surgical pathology and cancer chemotherapy
- Specific hospital outpatient services furnished to a beneficiary who is admitted to a Medicare-participating SNF, but who is not considered to be a SNF resident for purposes of SNF consolidated billing, with respect to those services that are beyond the scope of SNF comprehensive care plans
- Certain preventive services furnished to healthy persons, e.g., colorectal screening
- Hospital outpatient PPS for certain medical and other health services when they are furnished by other providers, such as CORFS, and HHAs, or to hospice patients for the treatment of a non-terminal illness.
- Implants

SERVICES EXCLUDED FROM THE SCOPE OF SERVICES PAID UNDER THE HOSPITAL OUTPATIENT PPS

The following services are excluded from the scope of services paid under outpatient PPS:

Excluded Services

- Services already paid under fee schedules or other payment systems including, but not limited to:
  - Screening mammographies
  - ESRD paid under the ESRD composite rate
  - Professional services of physicians and non-physicians paid under the Medicare physician fee schedule
  - Laboratory services paid under the clinical diagnostic laboratory fee schedule
  - Non-implantable DME, orthotics, prosthetics and prosthetic devices, prosthetic implants, and take-home surgical dressings paid under the DMEPOS fee schedule
- Hospital outpatient services furnished to SNF inpatients as part of his or her resident assessment or comprehensive care plan
- Services and procedures that require inpatient care
- Ambulance services, physical and occupational therapy, and speech/language services
- Drugs and supplies that are used within a dialysis session where payment is not included in the composite rate
- Take-home surgical dressings paid under the DMEPOS fee schedule

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM BILL TYPES

Types Of Bills Paid under OPPS

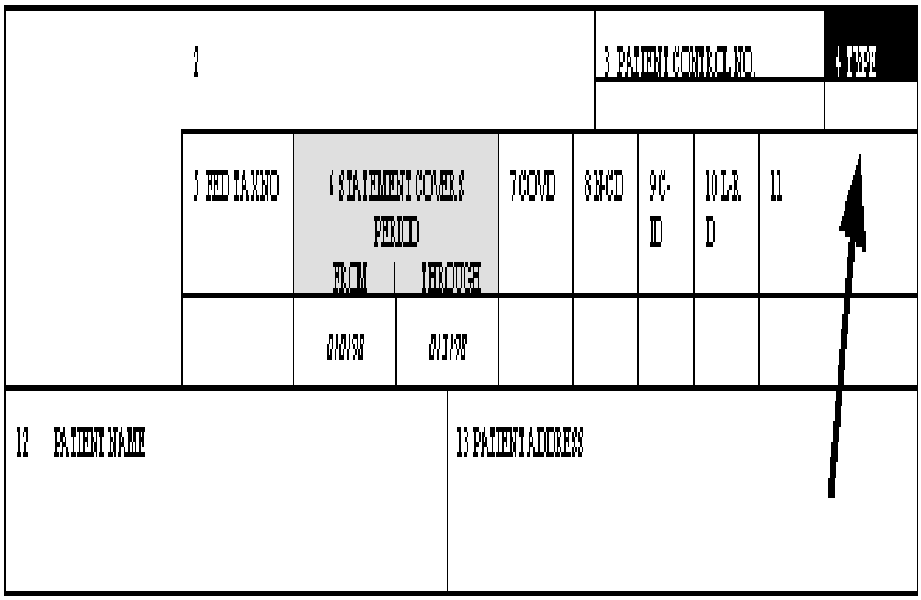
The bill type is a code indicating the specific type of bill (inpatient, outpatient, adjustments, cancels, late charges). This is a three-position field and is mandatory for all outpatient bills paid under the Outpatient Prospective Payment System (OPPS).

The three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care: it is referred to as the frequency code.

Data elements in the HCFA uniform billing specifications are consistent with the Form HCFA-1450. The type of bill is located in field 4 of the 1450. In the electronic specifications, the bill type is located in record type 40, position 25.

The bill types that will be affected by Outpatient Prospective Payment System are:

12x	Hospital Inpatient (Part B)
13x	Hospital Outpatient with CC 41
13x	Hospital Outpatient
14x	Hospital Referenced Diagnostics
34x	Home Health Agency (HHA)
75x	Comprehensive Outpatient Rehabilitation Facility (CORF)
76x	Community Mental Health Center (CMHC)



LINE ITEM DATES OF SERVICE

Line Item Dates of Service

Under the hospital OPPS, hospitals and CMHCS are required to report all services utilizing HCPCS coding in order to assure proper payment. This requirement applies to:

- Acute care hospitals
- Hospital outpatient departments
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Home Health Agencies
- Hospice patients for the treatment of a non-terminal illness

Under OPPS, line item dates of service are to be reported on all outpatient bills for each line where a HCPCS code is required, **including claims where the "from" and "through" dates are the same.**

Claims will be returned to providers if submitted

- With a HCPCS and no corresponding line item date of service, or
- With a line item date of service outside the 'statement covers' period
- Line item dates of service and no HCPCS code

Claim Example

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
250				*1*	*200*	*00*
510		*92002*	*070100*	*1*	*100*	*00*
519		*95805*	*070100*	*1*	*200*	*00*
510		*92002*	*070100*	*1*	*300*	*00*
943		*93797*	*070100*	*1*	*500*	*00*
943		*93797*	*070100*	*1*	*500*	*00*

REPORTING OF SERVICE UNITS

Service Units

The definition of service units is revised for hospital outpatient services and CMHCS where HCPCS code reporting is required.

A unit is now redefined as the "number of times the service or procedure being reported was performed according to the HCPCS code definition."

EXAMPLE: If the following procedures are performed once on a specific date of service, the entry in the "service units" field is as follows:

Service Units Example

90849	Multiple-family group psychotherapy	Units = 1
92265	Needle oculoelectro-myography, one or more extraocular muscles, one or both eyes, with interpretation and report	Units = 1
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests	Units = number of tests performed
95861	Needle electromyography two extremities with or without related paraspinal areas	Units = 1

EXAMPLE: If the HCPCS code has a 15-minute element, the entry in the service units field is as follows:

Service Units Example

97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	1 unit 8 min. to >23 min.

		2 units 23 min. to <38 min.
		3 units 38 min. to <53 min.
		4 units 53 min. to <68 min.
		5 units 68 min. to <83 min.
		6 units 83 min. to < 98 min.
		7 units 98 min. to <113 min.
		8 units 113 min. to <128 min.

The pattern remains the same for treatment times in excess of two hours. Hospitals should not bill for services performed for less than 8 minutes. The expectation is that a provider's time for each unit will average 15 minutes in length.

The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. (The total length of the treatment to the minute could be recorded instead.)

If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time.

For example, if 24 minutes of 97112 and 23 minutes of 97110 were furnished, then the total treatment time was 47 minutes; therefore, only three units can be billed for the treatment. The correct coding is two units of 97112 and one unit of 97110; thus assigning more units to the service that took more time.

Claim Example

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
420		*97112*	*070100*	*2*	*500*	*00*
420		*97110*	*070100*	*1*	*300*	*00*

Claims that do not contain service units for a given HCPCS code will be returned to the provider

DISCONTINUATION OF BILL TYPE 83X FOR SERVICES PAID UNDER OUTPATIENT PPS

Discontinuation of Bill Type 83X

Effective for dates of service July 1, 2000 and after, bill type 83x (ambulatory surgery center or ASC) will no longer be used for hospital ambulatory surgical claims. Hospitals must use 13x for ambulatory surgical claims submitted for outpatient prospective payment system (OPPS) payment. Claims submitted with bill type 13x will no longer be changed to 831 by the claims processing system.

The requirement to submit all charges for ASC services on the same claim has not changed. However, if preoperative lab services are included on the claim, the "from" date of the claim must include the date of the pre-op lab services.

- In the field "statement covers period from date" (1450 form locator 6), enter the earliest date services were rendered.
- Preoperative laboratory services must always have a line item date of service within the "from" and "thru" dates on the claim.
- Include all related services on one claim. An adjustment must be submitted if all services were not included on the original claim. Late charge bills (XX5) are no longer acceptable.
- Indian Health Services providers continue to bill surgeries utilizing bill type 83x.
- Critical Access providers continue to bill surgeries utilizing bill type 85X. bill type.

HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

HCPCS Level

In preparation for implementation of the hospital OPPS, hospitals and CMHCs are required to report services using HCPCS coding in order to receive proper outpatient payment. There are three levels of HCPCS codes:

- Level I codes contain the American Medical Association's Current Procedural Terminology (CPT) coding system. This level consists of all numeric codes.
- Level II codes (national codes) contain the codes for physician and non-physician services which are not included in CPT 4 codes, (e.g., ambulance , DME, orthotics and prosthetics). These are alphanumeric codes maintained jointly by HCFA, Blue Cross and Blue Shield Association and the Health Insurance Association of America (HIAA).
- Level III (local codes) contain the codes that Medicare fiscal intermediaries and carriers develop as needed.

There are certain HCPCS codes that are **not** used by Medicare. If hospitals report them on a claim with other services that are covered, the intermediary will deny the line item as non-covered.

HCPCS/Revenue Code Chart

The following chart represents all HCPCS coding to be reported and paid under the OPPS system.

*Revenue codes have not been identified for these procedures, as they can be performed in a number of revenue centers within a hospital, such as emergency room (450), operating room (360), or clinic (510). Providers are to report these HCPCS codes **under the revenue center where they were performed.**

The listing of HCPCS codes contained in the chart does not assure coverage of the specific service. Current coverage criteria applies.

It is intended to be used as a guide by hospitals to assist them in reporting services rendered. NOTE: this chart does not represent all HCPCS coding subject to OPPS but will be expanded at a later date.

* Please refer to page 48 for PHP codes.

HCPCS and Revenue Code Chart

Revenue Code	HCPCS Code	Description
*	10040-69990	Surgical Procedure
*	92950-92961	Cardiovascular
*	96570, 96571	Photodynamic Therapy
*	99170, 99185-99186	Other Services and Procedures
*	99291-99292	Critical Care
*	99440	Newborn Care
*	90782-90799	Therapeutic or Diagnostic Injections
*	D1050, D0240-D0274, D0277, D0460, D0472-D0999, D1510-D1550, D2970, D2999, D3460, D3999, D4260-D4264, D4270-D4273, D4355-D4381, D5911-D5912, D5983-D5985, D5987, D6920, D7110-D7260, D7291, D7940, D9630, D9930, D9940, D9950-D9952	Dental Services
*	92502-92596, 92599	Otorhinolaryngologic Services (ENT)
278	E0749, E0782-E0783, E0785	Implanted Durable Medical Equipment
278	E0751, E0753, L8600, L8603, L8610, L8612, L8614, L8619, L8630, L8641-L8642, L8658, L8670, L8699	Implanted Prosthetic Devices
302	86485-86586	Immunology
305	85060-85102, 86077-86079	Hematology
31X	80500-80502	Pathology – Lab
310	88300-88365, 88399	Surgical Pathology
311	88104-88125, 88160-88199	Cytopathology
32X	70010-76999	Diagnostic Radiology
333	77261-77799	Radiation Oncology
34X	78000-79999	Nuclear Medicine
37X	99141-99142	Anesthesia
413	99183	Other Services and Procedures
45X	99281-99285	Emergency
46X	94010-94799	Pulmonary Function
480	93600-93790, 93799, G0166	Intra Electrophysiological Procedures and

		Other Vascular Studies
481	93501-93571	Cardiac Catheterization
482	93015-93024	Stress Test
483	93303-93350	Echocardiography
51X	92002-92499	Opththalmological Services
51X	99201,99215,99241-99245,99271-99275	Clinic Visit
510, 517, 519	95144-95149,95163,95170, 95180,95199	Allergen Immunotherapy
519	95805-95811	Sleep Testing
530	98925-98929	Osteopathic Manipulative Procedures
636	A4642, A9500, A9605	Radionclides
636	90296-90379, 90385, 90389-90396	Immune Globulins
636	90476-90665, 90675-90749	Vaccines, Toxoids
73X	G0004-G0006, G0015	Event Recording ECG
730	93005-93014, 93040-93224, 93278	Electrocardiograms (ECGs)
731	93225-93272	Holter Monitor
74X	95812-95827, 95950-95962	Electroencephalo-gram (EEG)
762	99217-99220	Observation
771	G0008-G0010	Vaccine Administration
88X	90935-90999	Non-ESRD Dialysis
901	90870-90871	Psychiatry
903	90812-90815, 90823-90824, 90826-90829, 90910-90911,	Psychiatry
909	90880	Psychiatry
910	90801-90802, 90865, 90899	Psychiatry
914	90804-90809, 90816-90819, 90821, 90822, 90845, 90862	Psychiatry
915	90853, 90857	Psychiatry
916	90846-90847, 90849	Psychiatry
917	90901-90911	Biofeedback
918	96100-96117	Central Nervous System Assessments/Tests

HCPCS and Revenue Codes Chart

92X	95829-95857, 95900-95937, 95970-95999	Miscellaneous Neurological Procedures
920, 929	93875-93990	Non Invasive Vascular Diagnosis Studies
922	95858-95875	Electromyography (EMG)
924	95004-95078	Allergy Test
940	96900-96999	Special Dermatological Procedures
940	98940-98942	Chiropractic Manipulative Treatment
940	99195	Other Services and Procedures
943	93797-93798	Cardiac Rehabilitation

Reporting of HCPCS Codes

Reporting of HCPCS Codes

Under OPPS, when basing payment on CPT codes, the range of cost reflects hospitals' billing patterns in increasing levels of intensity. Increasing increments are due largely to hospitals' use of 'chargemaster' systems, which generate bills using predetermined charges for codes.

Hospitals should not use the lowest level code (e.g., CPT code 99201) to bill for all clinic visits. This would distort the data causing inflation in both the volume and cost of low-level clinic visits.

It is important that hospitals use the appropriate level of intensity of their clinic visits and reporting codes properly based on internal assessment of the charges for those codes rather than failing to distinguish between low- and mid-level visits because the payment is the same.

The billing information that hospitals report during the first years of implementation of OPPS will be vitally important to the revision of weights and other adjustments that affect payment in future years.

Each facility will be accountable for following its own system for assigning the different level of HCPCS codes.

Clinic Services

HCPCS Code 99291

Hospitals can use HCPCS code 99291 in place of, but not in addition to, a code for a medical visit/service in a clinic, emergency department.

The CPT definition of 'critical care' is the evaluation and management of a critically injured patient who requires periods of continual attendance of a physician.

Coding for Clinic and Emergency Visits

Coding for Clinic and Emergency Visits

Prior to OPPS, hospitals could report CPT code 99201 to indicate a visit of any type. Under OPPS, 31 codes are used to indicate visits with payment differentials for more or less intense service. Hospitals should code the visit using the following HCPCS codes:
92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204,99205,99211,99212,99213,99214,99215,99241, 99242,99243,99244,99245,99271,99272,99273,99274, 99275,99281,99282,99283,99284,99285,G0101 and G0175.
Hospitals should use CPT guidelines when applicable or crosswalk hospital coding structures to CPT codes. For example, a hospital that has 8 levels of emergency and trauma care depending on nursing ratios should walk those 8 levels to the CPT codes for emergency care.

HCPCS Code G0175

Hospitals can use HCPCS code G0175 in reporting a scheduled medical conference with the patient involving a combination of at least three health care professionals, and one of whom is a physician, but cannot be nurse.

Sterotatic Radiotherapy

New HCPCS Codes

Two new HCPCS codes have been developed to report radiation therapy in place of HCPCS code 61793. Providers should use these codes beginning with dates of service July 1, 2000.

- G0173 stereotactic radiosurgery, complete course of therapy in one session.
- G0174 stereotactic radiosurgery, requiring more than one session.

Initially, both codes will pay the same however, expect differences in cost to become apparent during the first year or 18 months of OPPS.

Implanted DME and Prosthetic Devices and Diagnostic Devices and Implanted Diagnostic Devices

Implanted DME and Prosthetic Devices and Diagnostic Devices

Implanted Durable Medical Equipment (DME) and implanted prosthetic devices are now paid under the Outpatient Prospective Payment System and no longer paid on fee schedule. The following are the appropriate HCPCS codes for payment under OPPS. **Do not bill your local carrier for dates of service on and after July 1, 2000.**

Implanted DME
E0749
E0782
E0783
E0785

Implanted Diagnostic Devices
C1361

Implanted Prosthetic Devices

E0751	E0753
L8600	L8603
L8610	L8612
L8613	L8614
L8630	L8641
L8642	L8658
L8670	L8699

MODIFIERS

Modifiers

A modifier is a two position alpha or numeric code that is added to the end of a HCPCS code to clarify the services being billed.

Modifiers provide a means by which a service can be altered without changing the procedure code. They add more information, such as the anatomical site, to the HCPCS code. In addition, they help to eliminate the appearance of duplicate billing and unbundling.

There are CPT-4 and Level II HCPCS modifiers. They are used to increase accuracy in reimbursement, coding consistency, editing, and to capture payment data. Billing accurately with modifiers is an integral part of the OPPS.

Use the modifiers identified below, when appropriate, for surgical procedures (HCPCS codes 10000–69999), radiology (HCPCS codes 70010–79999), and other diagnostic procedures (HCPCS codes 90700–99199).

Not all HCPCS codes will require modifiers

- Do not use a modifier to indicate an anatomical site location on body (modifier 50 or Level II modifiers) if the narrative definition of a code indicates multiple occurrences.

  EXAMPLE: The code definition indicates two to four lesions.
  11056 – Paring or cutting hyperkeratolic lesion, leg (e.g., corn or callous); two or four lesions. The code definition indicates multiple lesions.
  73565 – Radiologic examination; both knees, standing, anteroposterior. The code definition indicates the specific site.

- Do not use a modifier to indicate an anatomic site (modifier 50 or Level II modifiers) if the narrative definition of a code indicates the procedure applies to more than two sites.

  EXAMPLE: Code 11600 (Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less)

Special Guidelines for Radiology

Special Guidelines for Using Modifiers with Radiology Services

- Use modifiers 50, 52, 59,, 76, 77, and level II modifiers.
- Do not report a radiology procedure that was canceled.

Modifier for Bilateral Procedures

50 Bilateral Procedure

Modifier 50 Bilateral Procedure

Modifier 50 is used to report bilateral procedures that are performed at the same session. Report the appropriate HCPCS code and add the modifier 50 to the procedure code to identify that the procedure was performed on a contralateral site. Units should be reported as one.

EXAMPLE: Procedure 19000 (Puncture aspiration of cyst of breast) was performed on the right and left breast during the same operative session. This is billed as 1900050.

Modifier 50 Claim Example

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
360		*1900050*	*070100*	*1*	*400*	*00*

Use modifier 50 for;

- surgical procedures (CPT 10000-69990)
- radiology procedure if applicable
- any bilateral procedure performed on both sides at the same session

Do not use modifier 50 for:

- procedures identified by their terminology as “bilateral,” e.g., 27395 (Lengthening of hamstring tendon, multiple, bilateral)
- procedures identified as “unilateral or bilateral,” e.g., 52290 (Cystourethroscopy, with meatotomy, unilateral or bilateral)

Do not:

- submit two line items to report a bilateral procedure
- submit with modifiers RT and LT when modifier 50 applies

Payment Implications

- When modifier 50 is reported, reimbursement is for two procedures: PRICER will apply the rules for calculating payment for multiple procedures. The provider is Reimbursement at 150% of the group rate.
- Radiology is reimbursed at 200%. (Reimbursed is for two procedures)

Modifiers for Discontinued Services

52 Reduced Services

Modifier 52 Reduced Services

Modifier 52 is for radiology and other diagnostic procedures. It can also be used for surgery when the use of anesthesia was not an inherent part of performing the procedure.

Example: If a colonoscopy, HCPCS code 45378, flexible, promimal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) was started (conscious sedation had been administered), but is was found that the patient was inadequately prepped for the procedure, so the procedure was discontinued, and no exam of even the sigmoid was possible. This should be billed as 4537852

Modifier 52 Claim Example

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
*		***4538752***	***070100***	***1***	***500***	***00***

***Revenue code should be billed where the services were performed.**

Special Guidelines for Modifier 52

However, it is not appropriate to use modifier 52 if a portion of the intended procedure was completed and a code exists which represents the completed portion of the intended procedure.

Example: If a colonoscopy, HCPCS code 45378, was partially completed, that is, the colonoscopy was advanced as far as the splenic flexion, to the extent that the procedure meets the definition of a sigmoidoscopy, HCPCS code 45330, it is appropriate to bill that code. Otherwise, if no codes exists for what has been done, report the intended code with modifier 52.

Special guidelines for Modifier 52

- Code to the extent of the procedure that was performed and do not use modifier 52
- If no code exists for what has been done, report the intended code with modifier 52

73 Discontinued Outpatient Hospital Surgical Procedure (ASC) or Diagnostic Procedure/Service Prior to the Administration of Anesthesia

Modifier 73

Modifier 73 is used for surgical procedures for which anesthesia (general, regional, or local) is planned.

EXAMPLE: A patient is prepared for procedure 49590 "repair spigelian hernia". Before anesthesia is administered, the physician decides the procedure should not be performed. This is billed as 4959073.

Modifier 73 Claim Example

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
360		*4959073*	*070100*	*1*	*400*	*00*

Use modifier 73 for:

- procedures requiring anesthesia
- an outpatient hospital procedure discontinued
  - *after* the patient has been prepared for the procedure and/or
  - *before* the induction of anesthesia (e.g., local, regional block(s) or general anesthesia)

Do Not:

- use modifiers 52 and 73 together

Payment Implications

- A terminated procedure with modifier 73 will be discounted at 50%

Modifier 74

74 Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure or Diagnostic Procedure or Service after the Administration of Anesthesia

Modifier 74 is used for surgical procedures for which anesthesia (general,regional or local) has been started.

EXAMPLE: Anesthesia for procedure 38745 (Axillary lymphadenectomy: complete is given and the procedure has been started, but the physician terminates the procedure before it is complete. This is billed as 3874574.

Modifier 74 Claim Example

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
360		*3874574*	*070100*	*1*	*800*	*00*

Use modifier 74 for:

- procedures requiring anesthesia
- an outpatient hospital/ambulatory surgery center (ASC) or diagnostic procedure discontinued *after* the administration of anesthesia

Additional Instructions for Coding Discontinued Surgical Services

When multiple procedures were planned and there was a termination:

- If one of more of the procedures were completed, report the completed procedure(s) as usual. The other(s) planned and not started are not reported.
- If none of the planned procedures were completed, report the first procedure that was planned with modifier 73 or modifier 74. The others are not reported.

Modifier for Distinct Procedures

59 Distinct Procedural Services

Modifier 59

Modifier 59 is used for procedures/services that are not normally reported together, but may be performed under certain circumstances.

EXAMPLE: Procedures 23030 (Incision and drainage, shoulder area; deep abscess or hematoma) and 20103 (Exploration of penetrating wound; extremity) are performed on the same patient on the same date of service. The incision and drainage of the shoulder is the definitive procedure and any exploration of the area preceding this is considered an inherent part of the procedure. However, the exploration procedure was conducted on a different part of the same limb, adding the 59 modifier to code 23030 will explain the circumstance and prevent denial of the service. If these two codes were billed together without modifier 59, code 20103 would be denied.

Modifier 59 Claim Example

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
360		*23030*	*070100*	*1*	*800*	*00*
360		*2010359*	*070100*	*1*	*800*	*00*

Use modifier 59 for:

- Indicating that a procedure or service was distinct or independent from other services performed on the same day.
- Representing
  - different procedure or surgery,
  - different site or organ system,
  - separate incision, or
  - separate injury (or area of injury in extensive injuries) ***not*** ordinarily encountered or performed on the same day by the same physician
  - different session or patient encounter

Do not use modifier 59 if:

- a level II HCPCS modifier can be used to indicate different body areas

Modifier 76

Modifiers for Repeat Procedures

76 Repeat Procedure by the Same Physician

Modifier 76 is used to indicate that a procedure or service was repeated in a **separate session on the same day** by the same physician. This modifier may be reported for services ordered by physicians but performed by technicians. The procedure code is listed once and then listed again with modifier 76 added (two line items). The number of times that the procedure was repeated is reported on separate lines.

> **Example:** EKG 93005 (Electrocardiogram, routine EKG with at least 12 leads; with interpretation and report) is performed at 8 a.m. An EKG, 93005 is ordered and repeated at 1 p.m. The patient's condition requires another EKG, the physician orders it and the EKG is done at 10 p.m. This is billed as 93005, one unit (first line) and 9300576, two units (next line).

Modifier 76 Claim Example

Diagnostic Test

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
730		*93005*	*070100*	*1*	*300*	*00*
730		*9300576*	*070100*	*2*	*600*	*00*

For surgical procedures, report the HCPCS code without modifier 76 to indicate the first time the procedure was performed. For each additional time the procedure was performed, the HCPCS code is repeated with modifier 76 added. Do not use the units field to indicate that the procedure was repeated more than once on the same day.

Modifier 76 Claim Example

> **EXAMPLE:** Procedure 26615 open treatment of metacarpal fracture, single, with or without internal or external fixation,each bone. Later, while in the recovery room the internal fixation pin is dislodged, so

that the operating surgeon needs to repeat the procedure. This is reported as 26615 (first line) and 2661576 (next line). Both will have units reported as one.

Surgical Procedure

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
360		*26615*	*070100*	*1*	*200*	*00*
360		*2661576*	*070100*	*1*	*200*	*00*

77 Repeat Procedure by Another Physician

Modifier 77

Modifier 77 is used for a procedure performed that had to be repeated by a different physician in a separate session on the same day. The procedure code is listed once and then listed again with modifier 77 added. The number of times the procedure was repeated is reported on separate lines. Do not use the units field to indicate that the procedure was performed more than once on the same day.

For surgical procedures, report the HCPCS code without modifier 77 to indicate the first time the procedure was performed. For each additional time the procedure was performed, the HCPCS code is repeated with modifier 77 added. Do not use the units field to indicate that the procedure was performed more than once on the same day.

Example: Procedure 26615 Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone. Later, while in the recovery room the internal fixation pin is dislodged, and a different surgeon repeats the procedure. This is reported as 26615 (first line) and 2661577 (next line). Both will have units reported as one. The only difference is that a different physician repeats the procedure so that modifier 77 is used in place of 76.

Modifier 77 Claim Example

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
360		*26615*	*070100*	*1*	*200*	*00*
360		*2661577*	*070100*	*1*	*200*	*00*

Additional Guidelines for Coding Repeat Procedures
Modifiers 76 and 77

- If you are not sure who ordered the second procedure, or whether the same physician ordered both procedures, code based on the physician who performed the procedures.

- The procedure repeated must be the same procedure.

Modifier for Evaluation and Management Services

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure of Other Service

Modifier 25

Modifier 25 is billed with an evaluation and management (E & M) code to indicate that on the same day a procedure was performed, the patient's condition required a significant, separately identifiable E & M service (even though the E & M service may be necessary because of the symptom or condition for which the procedure was provided).

Use modifier 25 for an E & M service:

- that is above and beyond the procedure performed
- that is beyond the usual pre-operative and post-operative care associated with the procedure
- when a separate history was taken, a separate physical was performed, and a separate medical decision was made and is documented in the medical record

Modifier for Staged or Related Procedures

58 A Staged Or Related Procedure Or Service By The Same Physician During The Postoperative Period On the Same Day

Modifier 58

An example of modifier 58 is one were a needle biopsy is performed in the morning and the plan, which subsequently carried out, is to perform an excisional biopsy later in the day depending on the results of the surgical pathology report. **The post operative period refers to same calender day**

- planned prospectively at the time of the original procedure (staged)
- more extensive than the original procedure
- for therapy following a diagnostic surgical procedure

Do not use modifier 58 to report the treatment of a problem that requires a return to the operating room (see modifier 78).

Modifier for a Return Trip to the Operating Room

Modifier 78

78 Return to the Operating Room for a Related Procedure during the Postoperative Period

Modifier 78 is used to indicate that another procedure was performed during the postoperative period of the initital procedure that was performed earlier in the same day.

Example;: Procedure 23500, Closed treatment of clavicular fracture with manipulation; and following this it is subsequently decided that another procedure is required, such as 23515, (open treatment of clavicular fracture, with or without internal or external fixation. This is reported as 23500 on the first line and 2351578 on the next line.)

When reporting surgical procedures, each revenue code must have charges associated with the revenue code reported.

Modifier 78 Claim Example

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
360		*23500*	*070100*	*1*	*300*	*00*
360		*2351578*	*070100*	*1*	*300*	*00*

Use modifier 78 if:

- the subsequent procedure relates to the first procedure; ***and***
- the subsequent procedure requires the use of an operating room.

Modifier for an Unrelated Procedure during a Postoperative Period

Modifier 79

79 Unrelated Procedure or Service by the Same Physician during a Postoperative Period

Modifier 79 is used to indicate that the performance of a procedure or service by the same physician during the post-operative period was unrelated to the original procedure that was performed earlier in the day.

Modifier 79 Claim Example

***EXAMPLE*:** Procedure 20100 (Exporation of penetrating wound, separate procedure; extremity followed later in the day by procedure 43227 esophagoscopy, rigid or flexible with control bleeding, any method.

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
360		*20100*	*070100*	*1*	*800*	*00*
360		*4322779*	*070100*	*1*	*800*	*00*

HCPCS LEVEL II MODIFIERS

Level II Modifiers

The following HCPCS level II modifiers are added, as appropriate, primarily to codes for procedures performed paired organs etc., on eyelids, fingers, toes, or arteries. These modifiers are used to prevent erroneous denials when duplicate HCPCS codes are billed to report separate procedures performed on different anatomical sites or different sides of the body.

Guidelines for Level II Modifiers

Guidelines for Level II Modifiers

- When a modifier is needed, the most specific modifier should be used first.

  EXAMPLE: Use modifier E1 for the upper left eyelid, instead of modifier LT.

- If more than one level II modifier applies, repeat the HCPCS code on another line with the appropriate level II modifier.

  EXAMPLE: Code 26010 (drainage of finger abscess; simple) done on the left hand thumb and second finger would be billed: 26010FA (one line) and 26010F1 (separate line).

- Modifiers LT and RT
  - Apply to codes that identify procedures which can be performed on a contralateral anatomic sites (joints, bones) or on paired organs, extremities and, e.g., ears, eyes, nasal passages kidneys, lungs, ureters and ovaries
  - Required when the procedure is performed on only one side, to identify the side operated upon

Level II Modifiers

E1	Upper left, eyelid	**LC**	Left circumflex coronary artery (Hospitals use with codes 92980–92982, 92995, and 92996)	**TA**	Left foot, great toe
E2	Lower left, eyelid			**T1**	Left foot, second digit
E3	Upper right, eyelid			**T2**	Left foot, third digit
E4	Lower right, eyelid			**T3**	Left foot, fourth digit
FA	Left hand, thumb	**LD**	Left anterior descending coronary artery (Hospitals use with codes 92980–92982, 92995, and 92996)	**T4**	Left foot, fifth digit
F1	Left hand, second digit			**T5**	Right foot, great toe
F2	Left hand, third digit			**T6**	Right foot, second digit
F3	Left hand, fourth digit			**T7**	Right foot, third digit
F4	Left hand, fifth digit	**LT**	Left side (used to identify procedures performed on the left side of the body)	**T8**	Right foot, fourth digit
F5	Right hand, thumb			**T9**	Right foot, fifth digit
F6	Right hand, second digit				
F7	Right hand, third digit	**RC**	Right coronary artery (Use with codes 92980–92982, 92995, and 92996.)		
F8	Right hand, fourth digit				
F9	Right hand, fifth digit	**RT**	Right side (used to identify procedures performed on the right side of the body)		

Do not use modifiers LT and RT to report bilateral surgical procedures; use modifier 50 (Bilateral Procedure).

***EXAMPLE*:**

Example Number	Right side?	Left side?	Same operative session?	Same doctor?	Repeat Procedure same day?	Code	Service Units
1	Y					XXXXX**RT**	1
2		Y				XXXXX**LT**	1
3	Y	Y	Y			XXXXX**50**	1
4	Y	Y	N			XXXXX**RT**	1
						XXXXX**LT**	1
5	Y	Y	Y	Y	Y, right side* only	XXXXX**50**	1
						XXXXX**RT76**	1
6	Y	Y	Y	N	Y, right side* only	XXXXX**50**	1
						XXXXX**RT77**	1
7	Y			Y	Y, right side* only	XXXXX**RT**	1
						XXXXX**RT76**	1
8	Y			N	Y, right side* only	XXXXX**RT**	1
						XXXXX**RT77**	1

(XXXXX represents the five-digit CPT-4 code)
*Right side is used here for purposes of illustration only.
For the left side, the modifier LT should be used instead of RT.
Examples 4 through 8 above reflect very rare circumstances.
The use of modifier 50 (bilateral) or RT and LT as described in the grid above only applies to CPT4 codes where “bilateral” is not already inherent in the CPT code description.

Service	HCPCS Range	Modifier	Modifier Description	Hints
Surgery	10000-69999	50	Bilateral Procedure	- Use to report a procedure done bilaterally in same operative session. - Use only for paired organs/body parts. - Do not use if code indicates multiple occurrences. - Do not use if the code indicates the procedure applies to different body parts. - Do not use if code description included “bilateral” or “unilateral or bilateral.”
		73	Discontinued Outpatient Hospital Procedure Prior to the Administration of Anesthesia	- Use to report an outpatient procedure discontinued • When the physician terminates the procedure • After the patient is prepped for surgery and is in the surgery room, and • Before anesthesia is delivered. - If more than one procedure was planned, report only the procedure that was started.
		74	Discontinued Outpatient Hospital/Ambulatory Center (ASC) Procedure after the Administration of Anesthesia	- Use to report an outpatient procedure discontinued • When the physician terminates the procedure • After anesthesia is delivered. - If more than one procedure was planned, report only the procedure that was started.
		59	Distinct Procedural Service	- Use for procedures not normally reported together. - Use to indicate a procedure distinct or independent from other procedures performed on the same day. - Use to represent (not ordinarily performed on the same day): • Different procedure or surgery • Different site or organ system • Separate incision • Separate injury (or area of injury in extensive injuries) • Different session or patient encounter - Do not use if a level II modifier can be used.
		76	Repeat Procedure by Same	- Use when a procedure is repeated:

			Physician	• In a separate session • On the same day • By the same physician - The procedure repeated must be the same procedure (same HCPCS code).
		77	Repeat Procedure by Another Physician	- Use when a procedure is repeated: • In a separate session • On the same day • By a different physician - The procedure repeated must be the same procedure (same HCPCS code).
		58	A Staged or Related Procedure or Service by the Same Physician during the Postoperative Period of a previously performed procedure	- Use when the performance of a procedure during the post-operative period was performed on the same day • Planned prospectively at the time of the original procedure (staged) • More extensive than the original procedure • For therapy following a diagnostic surgical procedure - Do not use to report the treatment of a problem that requires a return to the operating room (see modifier 78).
		78	Return to the Operating Room for a Related Procedure during the Postoperative Period of a previously performed procedure	- Use to indicate that another procedure was performed during the postoperative period of the initial procedure on the same day - Use if the subsequent procedure: • Relates to the first procedure; and • Requires the use of an operating room.
		79	Unrelated Procedure or Service by the Same Physician during a Postoperative Period	- Use to indicate that a procedure performed: • During the post-operative period on the same day • By the same physician • Is unrelated to the original procedure
		RT/LT	Right Side/Left Side	- Use to identify procedures performed on the right/left side of a paired organ or central lateral anatomic site body. - Use when the procedure is performed on only one side to identify the side operated upon - Do not use if code indicates multiple occurrences.

				- Do not use if the code indicates the procedure applies to different body sites or anatomic structures - Do not use RT/LT if a more specific modifier is available. - Do not use RT and LT when modifier 50 is appropriate.
		E1 – E4, FA – F9, TA – T9	Eyelids Fingers Toes	- Use the most specific modifier available. - If more than one level II modifier applies, repeat with each of the appropriate level II modifiers. - Do not use if code indicates multiple occurrences. - Do not use if the code indicates the procedure applies to different body parts.
Radiology		50	Bilateral Procedure	- Use to report a procedure done bilaterally in same radiology session - Use only for paired organs/body parts - Do not use if code indicates multiple occurrences - Do not use if the code indicates the procedure applies to different body parts - Do not use if code description includes bilateral or unilateral
	70010-79999	52	Reduced Services	- Use to report a service that was: • Initiated • Partially rcompleted • No available HCPCS code describes the service performed - Do not report a radiology procedure that was canceled.
		59	Distinct Procedural Service	- Use for services not normally reported together. - Use to indicate a service distinct or independent from other services performed on the same day. - Use to represent (not ordinarily performed on the same day): • Different procedure, • Different site or organ system, • Separate incision • Separate injury (or area of injury in extensive injuries) - Do not use if a level II modifier can be used.

		76	Repeat Procedure by Same Physician	- Use when a service is repeated: • In a separate session • On the same day • By the same physician - The service repeated must be the same service (same HCPCS code).
		77	Repeat Procedure by Another Physician	- Use when a service is repeated: • In a separate session • On the same day • By a different physician - The service repeated must be the same service (same HCPCS code).
		79	Unrelated Procedure or Service by the Same Physician during a Postoperative Period	- Use to indicate that a service performed: • During the post-operative period of a procedure performed earlier in the day • By the same physician • Is unrelated to the original procedure
		RT/LT	Right Side/Left Side	- Use to identify services performed on the right/left side of a paired organ or central lateral anatomic site. - Apply to codes that identify services that can be performed on paired organs, e.g., ears, lungs, ovaries. - Use when the service is performed on only one side of a pair. - Do not use if code indicates multiple occurrences. - Do not use if the code indicates the procedure applies to different body parts. - Do not use RT/LT if a more specific modifier is available.
Other Diagnostic	90700-99199	59	Distinct Procedural Service	- Use for services not normally reported together. - Use to indicate a service distinct or independent from other services performed on the same day.

				- Use to represent (not ordinarily performed on the same day): • Different procedure, • Different site or organ system, • Separate incision • Separate injury (or area of injury in extensive injuries) • Different session or patient encounter - Do not use if a level II modifier can be used.
		76	Repeat Procedure by Same Physician	- Use when a service is repeated: • In a separate session • On the same day • By the same physician - The service repeated must be the same service (same HCPCS code).
		77	Repeat Procedure by Another Physician	- Use when a service is repeated: • In a separate session • On the same day • By a different physician - The service repeated must be the same service (same HCPCS code).
		79	Unrelated Procedure or Service by the Same Physician during a Postoperative Period	- Use to indicate that a service/procedure performed earlier in the day • During the post-operative period • By the same physician - Is unrelated to the original procedure

		RT/LT	Right Side/Left Side	- Use to identify services performed on the right/left side of a paired organ or centra lateral anatomic site - Apply to codes that identify services that can be performed on paired organs, e.g., ears, lungs, ovaries. - Use when the service is performed on only one sideof a paired organ or centra lateral anatomic site. - Do not use if code indicates multiple occurrences. - Do not use if the code indicates the procedure applies to different body parts. - Do not use RT/LT if a more specific modifier is available.
	92980-92982, 92995, 92996	LC LD RC	Left circumflex coronary artery Left anterior descending coronary artery Right coronary artery	- Use to identify vessel upon which the procedure was performed. - If more than one level II modifier applies repeat the HCPC code in another line with the level II modifier
Evaluation and Management	99201-99499	25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure of Other Service	- Use to indicate that the patient required a significant, separately identifiable E & M service on the same day a procedure was performed. - Use for an E & M service that: • Is beyond the usual pre-operative care associated with the procedure • A separate history was taken a separate physical performed, and medical separate decision made

Condition Code G0 (zero)

Condition Code G0

Hospitals must report condition code G0 in form locator 24-30 when distinct and independent visits on the same day in the same revenue center can be reported on separate claims with condition code G0 on the second and any subsequent claims.

> ***EXAMPLE***: A beneficiary went to the emergency room twice (morning and afternoon) on the same day for chest pain. This situation would apply if the beneficiary came back for a different or same reason.

Condition Code G0 Claim Example

Proper reporting of condition code G0 allows for payment under OPPS. If condition code G0 is not present and service units are greater than 1, the system will reject multiple medical visits on the same day with the same revenue code.

Billing Example 1 (one claim submitted)
One claim
Condition code G0 is one the claim

REV. CD.	HCPCS/	SERV.DATE	SERV.UNITS	TOTALCHARGES
450	99281	070100	2	800.00

Billing Example 2 (two claims submitted)

REV. CD.	HCPCS/	SERV.DATE	SERV.UNITS	TOTALCHARGES
450	99281	070100	1	400.00

Claim Two (separate claim)
Condition Code
G0

REV. CD.	HCPCS/	SERV.DATE	SERV.UNITS	TOTALCHARGES
450	99281	070100	2	800.00

Billing Example 3 (three claims submitted)
Claim one

REV. CD.	HCPCS/	SERV.DATE	SERV.UNITS	TOTALCHARGES
510	99281	070100	1	400.00

Claim Two (separate claim)
Condition Code G0

REV. CD.	HCPCS/	SERV.DATE	SERV.UNITS	TOTALCHARGES
510	99281	070100	1	400.00

Claim Three (separate claim)
Condition Code G0

REV. CD.	HCPCS/	SERV.DATE	SERV.UNITS	TOTALCHARGES
510	99281	070100	1	400.00

OBSERVATION AND EMERGENCY ROOM

Observation and Emergency Room Guidelines

All claims that span more than one day are subdivided into multiple days by the outpatient code editor (except claims for emergency room or observation room, revenue codes 45x and 762).

Claims for emergency room or observation visits will always be treated as if they occurred on a single day unless condition code 41 is present or the bill type is 76x.

Outpatient claims submitted for observation room services must be billed in the following manner:

- The service date is the date the patient occupied the observation bed.
- The observation room is identified with revenue code 762.
- The service units entered are the number of hours of observation room service.
- The reporting of HCPCS code range 99217-99220 is optional

Observation Room Example

EXAMPLE: 27 hours in observation

Observation Room Example

2					3 PATIENT CONTROL NO.					4 TYPE **131**
5 FED TAX NO		6 STATEMENT COVERS PERIOD FROM | THROUGH		7 COVD	8 N-CD	9 C-ID	10 L-RD	11		
		07012000	*07022000*							
12 PATIENT NAME				13 PATIENT ADDRESS						
14 BIRTH DATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	24 CONDITION 25 26 27 28 29 30 31

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM | THROUGH	37 A |
										B
										C

38		39 CODE	VALUE AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE AMOUNT
	A						
	B						
	C						
	D						

42 REV CODE	43 DESCRIPTION	44 HCPCS/RATES	45 SERVICE DATE	46 SERVICE UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
762		**99217**	070100	27	350	00			
360		11042	070100	1	800	00			

Emergency Room

Emergency Room

Outpatient claims submitted for emergency room must be billed in the following manner:

- The emergency room is identified with revenue code 45x.
- The HCPC code range is 99281-99285 and 99291.
- The service date is the date the service was provided in the emergency room, unless it spans over one day.
- **Note:** If the patient was in the emergency room after midnight, only one service date should be entered. (The date the patient entered the emergency room)
- Service units should be one.

Emergency Room Example

EXAMPLE: Emergency Room

2					3 PATIENT CONTROL NO.					4 TYPE
5 FED TAX NO		6 STATEMENT COVERS PERIOD FROM | THROUGH			7 COVD	8 N-CD	9 C-ID	10 L-RD	11	
		07012000	*07022000*							
12 PATIENT NAME				13 PATIENT ADDRESS						

14 BIRTH DATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	24	25	26	27	28	29 CONDITION	30	31

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM | THROUGH		37 A |
											B
											C

38		39 CODE	VALUE AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE AMOUNT
	A						
	B						
	C						
	D						

42 REV CODE	43 DESCRIPTION	44 HCPCS/RATES	45 SERVICE DATE	46 SERVICE UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
450		**99281**	070100	1	350	00			
320		70250	070100	1	100	00			

HOSPITAL INPATIENT SERVICES COVERED UNDER PART B

Payment may be made under Part B for medical and other health services when furnished by a participating hospital to an inpatient of a hospital when payment for these services cannot be made under Part A.

Inpatient Part B Services – (Bill type 12x)

Bill Type 12X

Under Outpatient Prospective Payment System, preventive care services have been added to the list of services billable on a 12x type of bill. Bill for the following services furnished directly or under arrangements to inpatients whose benefit days are exhausted or who are otherwise not entitled to have payment made under Part A.

- Diagnostic x-ray tests, diagnostic laboratory, and other diagnostic tests.
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the functions of a permanently inoperative or malfunctioning internal body organ, including replacement or repair of such devices.
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacements required because of breakage, wear, loss, or change in the patient's physical condition.
- Outpatient physical therapy services furnished inpatients.
- Outpatient speech pathology services furnished inpatients.
- Outpatient occupational therapy services furnished inpatients.
- Screening mammography services. (Revenue Code 403**)**
- Screening pap smears (Revenue Code 311) and pelvic exams. (Revenue Code 770)
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines. (Revenue Code 636)

- Colorectal screening**.** (Revenue code as appropriate depending on procedure/test performed)
- Bone mass measurements. (Revenue Code 320)
- Diabetes self-management. (Revenue Code 942)
- Prostate screening. (Revenue Code 30X and 770)

Changes to Billing Procedures for Inpatient Part B and Outpatient Hospital Services

Changes for 12X

- The claim's line items will be extended to 450 lines.
- Hospitals are required to report a line item date of service for every line where a HCPCS code is required. **This includes claims where the "from" and "through" dates are the same.**
- A line item date of service is required on all clinical diagnostic laboratory claims.
- When HCPCS codes are required for hospital outpatient services, the units must be equal to the number of times the procedure/service being reported was performed according to the definition of the HCPCS code.

EXAMPLE:

Example of 12X Bill Type

2					3 PATIENT CONTROL NO.							4 TYPE 121
5 FED TAX NO		6 STATEMENT COVERS PERIOD FROM | THROUGH			7 COVD	8 N-CD	9 C-ID	10 L-RD	11			
		070100	*070300*									
12 PATIENT NAME					13 PATIENT ADDRESS							
14 BIRTH DATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	24	25 CONDITION	26
27 CONDITION	28	29	30	31								

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM | THROUGH		37 A |
											B
											C

38		39 CODE	VALUE AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE AMOUNT
	a						
	b						
	c						
	d						

42 REV CODE	43 DESCRIPTION	44 HCPCS/RATES	45 SERVICE DATE	46 SERVICE UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
320		***71020***	***070100***	***5***	***300***	***00***			
480		***93600***	***070300***	***1***	***500***	***00***			
730		***93005***	***070300***	***1***	***300***	***00***			

BILLING CHANGES FOR CMHC AND PARTIAL HOSPITALIZATION SERVICES

The Balanced Budget Act (BBA) (P.L. 105-33), requires payment to be made under a prospective payment system for partial hospitalization services provided in a Community Mental Health Center (CMHC).

Billing Changes for Partial Hospitalization Services

The following reporting requirements are required to assure proper payment under OPPS. Partial hospital services require the following information:

- HCPCS codes and revenue codes that best describe the services furnished.
- A line item date of service is required for each revenue line on claims that span more than one date-
- "Service Units" are consistent with the HCPCS code definition.
- Claims for partial hospitalization services must include a mental health diagnosis for each day of service.

Billing Requirements

Billing Requirements

CMHCs must submit charges for partial hospitalization services with bill type 76X. Hospital outpatient providers should submit using bill type 13X. Bill type 14X has been discontinued for partial hospitalization services.

Listed below are the acceptable HCPCS codes for each revenue code billable by a partial hospitalization program:

Revenue Codes	**Description**	**HCPCS Code**
250	Drugs	Not required
43X	Occupational Therapy (Partial Hospitalization)	G0129*
904	Activity Therapy (Partial Hospitalization)	Q0082**
910	Psychiatric General Services	90801, 90802, 90875, 90876,

		90899, or 97770
914	Individual Psychotherapy	90816, 90818, 90821, 90823, 90826, or 90828
915	Group Psychotherapy	90849, 90853, or 90857
916	Family Psychotherapy	90846, 90847, or 90849
918	Psychiatric Testing	96100, 96115, or 96117
942	Education Training (Partial Hospitalization)	G0172***

*G0129 Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day.

Q0082 Activity therapy furnished as a component of a partial hospitalization treatment program, [e.g., music, dance, art or play therapies that are not primarily recreational], **per day (new narrative).

***G0172 Training and educational services furnished as a component of a partial hospitalization treatment program, per day.

The remaining items on the claim should be completed in accordance with the bill completion instructions in §414 of the Outpatient Physical Therapy/Comprehensive Outpatient Rehabilitation Facility/Community Mental Health Center Manual (HCFA-Pub. 9) for CMHCs and in accordance with (Hospital Manual).

Reporting of Service Units

The number of visits should not be reported as units. Report "Service Units," as the number of times the service or procedure was performed, as defined by the HCPCS code.

EXAMPLE: A beneficiary received psychological testing (HCPCS code 96100, which is defined in one hour intervals) for a total of 3 hours during one day. The CMHC/hospital reports revenue code 918, HCPCS code 96100, and three units.

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
918	*Psychological Testing*	*96100*	*070100*	*3*	*180*	*00*

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (minutes, hours or days), hospital outpatient departments/CMHCs should not bill for sessions of less than 45 minutes.

Claims will be returned to the provider that contain more than one unit for HCPCS codes G0129, Q0082, and G0172 or that do not contain service units for a given HCPCS code.

Use the most appropriate HCPCS code available to describe the service provided.

EXAMPLE: For example, if a beneficiary receives 50 minutes of individual psychotherapy in a single session, bill with HCPCS code 90818 (Individual psychotherapy,…, approximately 45 to 50 minutes…) as opposed to two units of 90816 (Individual psychotherapy,…, approximately 20 to 30 minutes…).

NOTE: Service units are required for drugs and biologicals (revenue code 250)

Line Item Date of Service Reporting

A line item date of service is required for each revenue code line for partial hospitalization claims that span two or more dates. This means each service (revenue code) provided must be repeated on a separate line item along with the date the service was provided for every occurrence. Service date format should be MMDDYY. Examples are shown below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the hard copy UB-92 (HCFA-1450), report as follows:

EXAMPLE

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	
915	*Group Therapy*	*90849*	*070500*	*1*	*80*	*00*
918	*Psychological Testing*	*96100*	*071200*	*3*	*180*	*00*
915	*Group Therapy*	*90849*	*072900*	*2*	*160*	*00*

Claims that span two or more dates will be returned to the provider if a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported are outside of the “statement covers” period.

Professional Services provided to Partial Hospitalization Patients:

The services listed below are the only professional services that are separately covered in a hospital outpatient partial hospitalization program or CMHC. These professional services should be billed to the Medicare Part B carrier:

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;
- PA services, as defined in §1861(s)(2)(K)(i) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and,
- Clinical psychologist services, as defined in §1861(ii) of the Act.

The services of other practitioners, (including clinical social workers and occupational therapists) are bundled in the OPPS payment when furnished to CMHC/outpatient hospital patients. The CMHC/hospital must bill the intermediary for such non-physician practitioner services as part of the partial hospitalization services. Payment for these services is then made to the CMHC/hospital as part of the APC payment.

Payment

For services provided on or after July 1, 2000, reimbursement for partial hospitalization will be based on the partial hospitalization per diem APC amount. Hospitals/CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time of the service.

OPPS reporting requirements

Provider Reporting Requirements

Providers receiving payments under the Outpatient Prospective Payment System (OPPS) cannot include July 2000 and August 2000 dates of service on the same claim. All services performed on the same day must be submitted on the same claim except: demand bills condition code 20 and 21, repetitive services and condition code GO. The "from" and "through" dates must reflect the day services are performed. Every effort should be made to report all services performed on the same day on the same claim to assure proper payment under OPPS.

Professional component

Professional Component

Beginning with dates of service July 1, 2000, outpatient claims paid under OPPS will no longer need to report professional component charges reported in value code 05 to specific line items on the claim. With line item date of service reporting there is no way to correctly allocate professional component charges reported in value code 05 to a specific line item on the claim.

Corneal Tissue Acquisition Costs

Corneal Tissue Costs

HCFA has decided not to package payment for corneal tissue acquistion costs with the APC payment for corneal tissue transplant procedures. Payment will be based on the hospital's reasonable cost incurred to acquire corneal tissue. Final payment will be subject to cost report settlement. To receive payment for corneal acquisition costs, hospitals must submit a bill using HCPCS code V2785. Providers should report their charges for corneal tissue on the bill.

CONDITION CODES 20 AND 21

Condition Codes 20 and 21

Hospitals and CMHCs may report condition code 20 and 21 when they realize the services are excluded from coverage, but

- The beneficiary has requested a formal determination (condition code 20)
- The provider is requesting a denial notice from Medicare to bill Medicaid or other insurer (condition code 21)

When billing for condition code 20 or 21, a separate claim must be submitted for non –covered charges.

EXAMPLE:

Covered Services and Demand Bill same day

14 BIRTH DATE	15 SEX	16 17 MS DATE	18 ADMISSION HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	24 25 26 27 28 29 CONDITION	30	31

20

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM THROUGH	37 A | B C

38		39 CODE	VALUE AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE AMOUNT
	a						
	b						
	c						
	d						

42 REV CODE	43 DESCRIPTION	44 HCPCS/RATES	45 SERVICE DATE	46 SERVICE UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
510		**92591**	**070200**	**1**	**300 00**	**300 00**	
001					**300 00**	**300 00**	

EXAMPLE:

14 BIRTH DATE	15 SEX	16 17 MS DATE	18 ADMISSION HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	24 25 26 27 28 29 CONDITION	30	31

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM THROUGH	37 A | B C

38		39 CODE	VALUE AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE AMOUNT
	a						
	b						
	c						
	d						

42 REV CODE	43 DESCRIPTION	44 HCPCS/RATES	45 SERVICE DATE	46 SERVICE UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49

510		99201	070200	1	100	00			
001					100	00			

REPETITIVE SERVICES

Repetitive Services

The following revenue categories are considered repetitive Part B services and must be continuously billed monthly to receive the proper reimbursement, although not all services are paid under OPPS.

Service	Revenue Code
Therapeutic Radiology	330-339
Therapeutic Nuclear Medicine	342
Respiratory Therapy	410-419
Occupational Therapy	430-439
Speech Therapy	440-449
Inpatient Renal Dialysis	800-804
Physical Therapy	420-429
Kidney Dialysis Treatments	820-859
Cardiac Rehabilitation Services	482 and 943
Psychological Services	910-919

Monthly billing is expected if the patient is being seen repeatedly during a monthly billing period. If the patient has an isolated service, that service may be billed as a single date of service claim.

PROCEDURES FOR SUBMITTING LATE CHARGES VS. ADJUSTMENTS

Submitting Late charges vs. Adjustments

Providers billing under Outpatient Prospective Payment System (OPPS) may not submit a late charge bill for bill types 12x, 13x, 14x, 34x, 75x, 76x or any claim containing condition code 07 and certain HCPCS codes. They must submit an adjustment bill for any service required to be billed with HCPCS codes, units, and line item dates of service by reporting a "7" in the third position of the bill type.

The submission of an adjustment bill, instead of a late charge bill, will ensure proper duplicate detection, bundling, correct application of coverage policies and proper editing by OCE, and payment under OPPS.

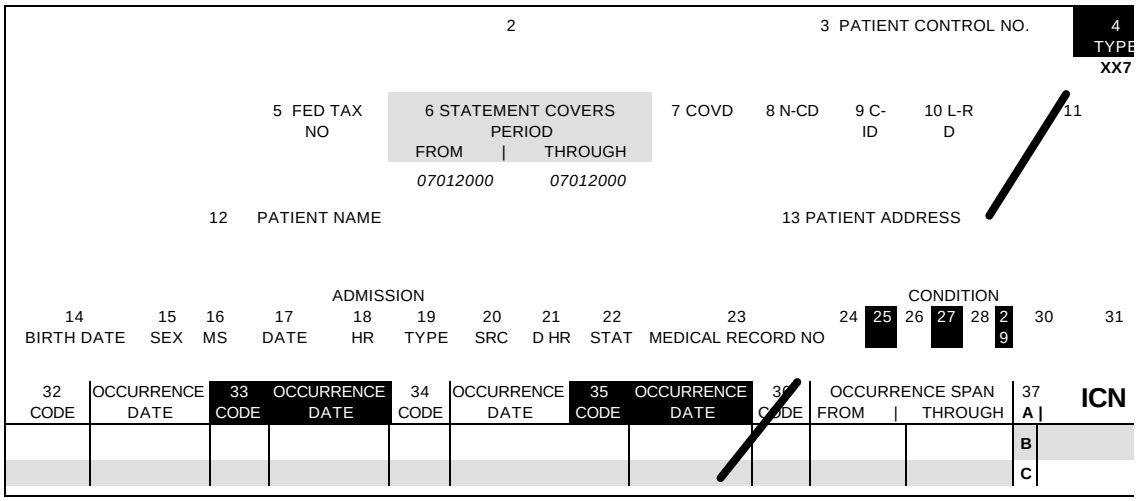
One of the following claim change condition codes must be included on each adjustment. Adjustment claims should be coded to reflect the way the claim should process.

Adjustment condition codes

Condition Code	Bill Type	Explanation
D0 (zero)	XX7	Changes in service dates
D1	XX7	Changes in charges
D2	XX7	Changes in revenue codes/HCPCS
D3	XX7	Second or subsequent interim PPS bill
D4	XX7	Change in GROUPER input (diagnosis or procedure)
D5	XX8	Cancel only to correct a HICN or provider identification number
D6	XX8	Cancel only to repay a duplicate payment or OIG overpayment and DRG window
D7	XX7	Change to make Medicare the secondary payer
D8	XX7	Change to make Medicare the primary payer
D9	XX7	Any other change
E0	XX7	Change in patient status

EXAMPLE:

Adjustment Claim



PAYMENT UNDER OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) FOR CERTAIN SERVICES PROVIDED IN VARIOUS SETTINGS

Only certain services will be paid under OPPS for services provided in a CORF or HHA, and for hospice patients.

- Condition code 07 is used to identify services rendered to a hospice patient that are unrelated to terminal care.
- Vaccines, antigens, splints, and casts unrelated to terminal care that are provided to a hospice patient at a site other than a hospital outpatient department, are also paid under OPPS.
- Community mental health centers bill type 76x, APC 33, is paid under OPPS.
- Vaccines provided in a CORF are also paid under OPPS.

All other services are paid per diem.

Miscellaneous Services Paid Under OPPS

			Service			
Site	**Type of Bill**	**Condition Code**	**Vaccine**	**Antigens**	**Splints**	**Casts**
CORF	75x		X			
HHA	34x		X	X	X	X
Not hospital, OPT, CHMC, CORF or HHA	Any bill type except 12x, 13x, 14x, 34, 74x, 75x or 76x	07		X	X	X

Vaccines, antigens, splints, and casts are specified by lists of HCPCS codes in the following chart.

Category	Code
Antigens	95144-95149,95165, 95170, 95180, 95199
Vaccines	90657- 90659, 90732, 90744, 90746, 90748, G0008, G0009, G0010
Splints	29105- 29131, 29505 – 29515
Casts	29000 –29085,29305,29450,29700 – 29750, 29799

MISCELLANEOUS ISSUES

Drugs or Biologicals

Designated Drugs or Biologicals

Certain designated drugs and biologicals will be identified by outpatient code editor as eligible for payment at 95% of the average wholesale price and assigned to a special APC. The Pricer program will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated drug and biological. Certain new designated drugs and biologicals may be approved for payment. The payment for the newly approved items will be calculated in the same manner as listed above for current designated drugs and biologicals. These new designated drugs and biologicals will be identified separately from the current designated drugs and biologicals.

Included in designated drugs and biologicals are:

- Orphan drugs, as designated under section 526 of the Federal Food, Drug and Cosmetic Act
- Current cancer therapy drugs, biologicals, and brachytherapy devices. These items are those drugs or biologicals that are used in cancer therapy including (but not limited to) chemotherapeutic agents, antiemetics, hematopietic growth factors, colony stimulating factors, biological response modifiers, bisphosonates, and brachytherapy devices.
- Current radio/pharmaceutical drugs and biological products used for diagnostic, monitoring, or therapeutic purposes.
- New drugs or biologicals.

In order to receive proper payment for drugs or biologicals, the provider must bill with revenue code 636 (drugs that require detail coding) and the HCPCS codes listed on the following pages.

Medicare Outpatient PPS Requests Received for Recognition As New Technology Or Pass Through Payments

CPT/HCPCS	Description
I. Pass-Through Items	
A4642	Satumomab pendetide per dose
CPT/HCPCS	**Description**
A9502	Technetium Tc 99 M tetrofosmin
A9600	Strontium-89 chloride
A9605	Samarium sm 153 lexidronamm
J0130	Abciximab
J0205	Alglucerase injection
J0207	Amifostine
J0256	Alpha 1 proteinase inhibitor
J0286	Amphotericin B lipid complex
J0476	Baclofen intrathecal trial
J0585	Botulinum toxin a per unit
J0640	Leucovorin calcium injection
J0735	Clonidine hydrochloride
J0850	Cytomegalovirus imm IV /vial
J1190	Dexrazoxane HCl injection
J1260	Dolasetron mesylate
J1325	Epoprostenol injection
J1436	Etidronate disodium inj
J1440	Filgrastim 300 mcg injeciton
J1561	Immune globulin 500 mg
J1562	Immune globulin 5 gms
J1565	RSV-ivig
J1620	Gonadorelin hydroch/ 100 mcg
J1626	Granisetron HCl injection
J1745	Infliximab injection
J1785	imiglucerase /unit
J1825	Interferon beta-1a
J1830	Interferon beta-1b / .25 MG
J1950	Leuprolide acetate /3.75 MG
J2275	Morphine sulfate injection
J2352	Octreotide acetate injection
J2355	Oprelvekin injection
J2405	Ondansetron hcl injection
J2430	Pamidronate disodium /30 MG
J2545	Pentamidine isethionte/300mg
J2765	Metoclopramide hcl injection
J2790	Rho d immune globulin inj
J2820	Sargramostim injection
J2994	Retavase
J3010	Fentanyl citrate injeciton
J3280	Thiethylperazine maleate inj
J3305	Inj trimetrexate glucoronate

J7190	Factor viii
J7191	Factor VIII (porcine)
J7192	Factor viii recombinant
J7194	Factor ix complex
J7197	Antithrombin iii injection
J7198	Anti-inhibitor
J7310	Ganciclovir long act implant
J7505	Monoclonal antibodies
J7913	Daclizumab, Parenteral, 25 m
J8510	Oral busulfan
J8520	Capecitabine, oral, 150 mg
J8530	Cyclophosphamide oral 25 MG
J8560	Etoposide oral 50 MG
J8600	Melphalan oral 2 MG
J8610	Methotrexate oral 2.5 MG
J9000	Doxorubic hcl 10 MG vl chemo
J9001	Doxorubicin hcl liposome inj
J9015	Aldesleukin/single use vial
J9020	Asparaginase injection
J9031	Bcg live intravesical vac
J9040	Bleomycin sulfate injection
J9045	Carboplatin injection
J9050	Carmus bischl nitro inj
J9060	Cisplatin 10 MG injeciton
J9065	Cladribine per 1 MG
J9070	Cyclophosphamide 100 MG inj
J9093	Cyclophosphamide lyophilized
J9100	Cytarabine hcl 100 MG inj
J9120	Dactinomycin actinomycin d
J9130	Dacarbazine 10 MG inj
J9150	Daunorubicin
J9151	Daunorubicin citrate liposom
J9165	Diethylstilbestrol injection
J9170	Docetaxel
J9181	Etoposide 10 MG inj
J9185	Fludarabine phosphate inj
J9190	Fluorouracil injection
J9200	Floxuridine injection
J9201	Gemcitabine HCl
J9202	Goserelin acetate implant
J9206	Irinotecan injection
J9208	Ifosfomide injection
J9209	Mesna injection
J9211	Idarubicin hcl injeciton
J9212	Interferon alfacon-1
J9213	Interferon alfa-2a inj
J9214	Interferon alfa-2b inj
J9215	Interferon alfa-n3 inj
J9216	Interferon gamma 1-b inj
J9218	Leuprolide acetate injeciton
J9230	Mechlorethamine hcl inj

J9245	Melphalan hydrochl 50 MG
J9250	Methotrexate sodium inj
J9265	Paclitaxel injection
J9266	Pegaspargase/singl dose vial
J9268	Pentostatin injection
J9270	Plicamycin (mithramycin) inj
J9280	Mitomycin 5 MG inj
J9293	Mitoxantrone hydrochl / 5 MG
J9310	Rituximab
J9320	Streptozocin injection
J9340	Thiotepa injection
J9350	Topotecan
J9360	Vinblastine sulfate inj
J9370	Vincristine sulfate 1 MG inj
J9390	Vinorelbine tartrate/10 mg
J9600	Porfimer sodium
Q0136	Non esrd epoetin alpha inj
Q0160	Factor IX non-recombinant
Q0161	Factor IX recombinant
Q0163	Diphenhydramine HCl 50mg
Q0164	Prochlorperazine maleate 5mg
Q0166	Granisetron HCl 1 mg oral
Q0167	Dronabinol 2.5mg oral
Q0169	Promethazine HCl 12.5mg oral
Q0171	Chlorpromazine HCl 10mg oral
Q0173	Trimethobenzamide HCl 250mg
Q0174	Thiethylperazine maleate10mg
Q0175	Perphenazine 4mg oral
Q0177	Hydroxyzine pamoate 25mg
Q0179	Ondansetron HCl 8mg oral
Q0180	Dolasetron mesylate oral
Q0187	Factor viia recombinant
Q2002	Elliot's B solution
Q2003	Aprotinin, 10,000 kiu
Q2004	Treatment for bladder calcul
Q2005	Corticorelin ovine triflutat
Q2006	Digoxin immune FAB (Ovine),
Q2007	Ethanolamine oleate, 1000 ml
Q2008	Fomepizole, 1.5 G
Q2009	Fosphenytoin, 50 mg
Q2010	Glatiramer acetate, 25 mgeny
Q2011	Hemin, 1 mg
Q2012	Pegademase bovine inj 25 I.U
Q2013	Pentastarch 10% inj, 100 ml
Q2014	Sermorelin acetate, 0.5 mg
Q2015	Somatrem, 5 mg
Q2016	Somatropin, 1 mg
Q2017	Teniposide, 50 mg
Q2018	Urofollitropin, 75 I.U.
Q2019	Basiliximab
Q2020	Histrelin Acetate

Q2021	Lepirdin
Q3001	Brachytherapy Seeds
Q3002	Gallium Ga 67
Q3003	Technetium Tc99m Bicisate
Q3004	Xenon Xe 133

NOTE: Please refer to HCFA web site at www.hcfa.gov New information added to this list.

Designated Devices

Designated Devices

Certain designated new devices will be identified by outpatient code editor as eligible for payment based on the reasonable cost of the new device. The Pricer program will determine the proper payment amount for these APCs, as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device.

In order for providers to receive payment for designated devices, they must bill with the HCPCS code listed below:

New Technology Items

CPT/HCPCS	Description
53850	Prostatic Microwave Thermotx
53852	Prostatic RF Thermotx
G0125	Lung Image (PET)
G0126	Lung Image (PET)
G0163	Lung Image (PET) Staging
G0164	PET for Lymphoma Staging
G0165	PET for Rec of Melanoma/MET Ca
G0166	Extrnl Counterpulse, Per Tx

Process for Identifying Items Potentially Eligible for Payment as New Technologies or Pass-Throughs

A manufacturer or other interested party who wishes to bring items that may be eligible for payment as new technologies or under the pass-through provision to our attention should mail their requests for consideration to the following address ONLY:

PPS New Tech/Pass-Throughs, Division of Practitioner and Ambulatory Care
Mailstop C4-03-06
Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244-1850

To be considered, requests **MUST** include the following information:

- Trade/brand name of item.
- A detailed description of the clinical application of the item, including HCPCS code(s) to identify the procedure(s) with which the item is used.
- Current wholesale cost of the item.
- Current retail cost of the item (i.e., actual cost paid by hospitals net of .all discounts, rebates, and incentives in cash or in-kind).
- For drugs, submit the most recent average wholesale price (AWP) of the drug and the date associated with the AWP quote.
- If the item is a service, itemize the costs required to perform the procedure, e.g., labor, equipment, supplies, overhead, etc.
- If the item requires FDA approval, submit information that confirms receipt of FDA approval and the date obtained.
- If the item already has an assigned HCPCS code, include the code and its descriptor in your submission, plus a dated copy of the HCPCS code recommendation application previously submitted for this item.
- If the item does not have an assigned HCPCS code, follow the procedure discussed, below, in section IV for obtaining HCPCS codes and submit a copy of the application with your payment request.
- Name, address, and telephone number of the party making the request.

Process for Obtaining HCPCS Codes

Some items not yet known do not yet have assigned HCPCS codes. HCFA expects to use national HCPCS codes in the hospital outpatient PPS to the greatest extent possible. These codes are established by a well-ordered process that operates on an annual cycle, starting with submission of information by interested parties due by April 1 and leading to announcement of new codes in October of each year.

Considering the exigencies of implementing a new system, HCFA intends to establish temporary codes in 2000 to permit implementation of additional payments for other eligible items

effective beginning October 1, 2000. The process for submitting information will be the same as for national codes.
For items that might be candidates for payment as new technologies or pass-throughs but that **DO NOT** have established HCPCS codes, submit the regular application for a national HCPCS code in accordance with the instructions found on the Internet at http://www.hcfa.gov/medicare/hcpcs.htm. Send applications for national HCPCS codes to:

C. Kaye Riley, HCPCS Coordinator, Health Care Financing Administration
Mailstop C5-08-27
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Outliers

Outliers

The Pricer program will calculate outlier payments on a claim-by-claim basis. The outlier payment will be calculated by:

- Calculating the costs related to the OPPS service on the claim by multiplying the total charges for covered OPPS service by an outpatient cost-to-charge ratio;
- Determining whether these cost exceed 2.5 times the OPPS payments (APC payment plus any transitional pass through amounts for drugs, biologicals and or devices) for the claim; and
- If costs exceed 2.5 times the OPPS payments, the outlier payment is calculated as 75 percent of the amount by which the claim costs exceed the threshold.

The result will be output from Pricer for the standard system to capture and store as value code 17, which is currently used to identify outliers.

PROGRAM MANUALS ON THE INTERNET

Program Manuals on the Internet

The Health Care Financing Administration (HCFA) has posted its Medicare manuals on the Internet. These manuals are available to download as a "zip" file.
The HCFA homepage can be found at:

http://www.hcfa.gov

To select and download a Medicare manual, use the following steps:

1. Go to the HCFA homepage
2. Click on Medicare
3. Click on laws and regulations
4. Click on professional and technical information
5. Click on Medicare Prof/Tech Publication
6. Choose selection 1 – General Information, or
   Choose selection 2 – Medicare Manuals download

HCFA Manuals

Manuals current available to be downloaded are:

HCFA-Pub. 6	Coverage Issues Manual
HCFA-Pub. 9	Outpatient Rehabilitation/CORF/CMHC Manual
HCFA-Pub. 10	Hospital Manual
HCFA-Pub. 11	Home Health Agency Manual
HCFA-Pub. 12	Skilled Nursing Facility Manual
HCFA-Pub. 15-1	Provider Reimbursement (PRM) Manual, Part I
HCFA-Pub. 15-2	Provider Reimbursement (PRM) Manual, Part II
HCFA-Pub. 19	Peer Review Organization (PRO) Manual
HCFA-Pub. 21	Hospice Manual
HCFA-Pub. 24	State Buy-In Manual
HCFA-Pub. 27	Rural Health Clinic Manual/FQHC
HCFA-Pub. 29	Renal Dialysis Facility Manual
HCFA-Pub. 45	State Medicaid Manual